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REPORT NO. 2

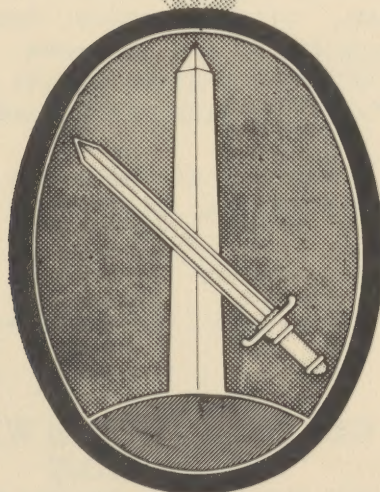
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MONTHLY HEALTH REPORT

Military District of Washington



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This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



MAJOR GENERAL THOMAS W. HERREN
COMMANDING
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Washington 25, D. C.

COMMAND RESPONSIBILITY



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

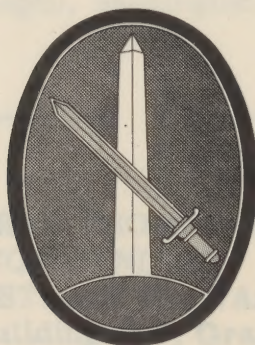
Robert E. Bitner

ROBERT E. BITNER
Colonel, MC
Surgeon



CONTENTS

	PAGE
ADMINISTRATIVE SERVICE	
Command Responsibility	1
Army Nurse Corps Enlist Support of Nursing Schools in New Drive	1
The Role of the Medical Department in Past Wars	2
Disinfecting Gas Masks	2
Table -- Hospital Mess Administration	13
Table -- Outpatient Service	13
CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM	
The Industrial Health Team	14
DENTAL SERVICE	
Table -- Dental Service	13
PREVENTIVE MEDICINE	
General Comment	7
Communicable Disease	7
Table -- General Data	8
Table -- Admissions, Specified Diseases	8
Venereal Disease	9
Table -- New Venereal Disease Cases	9
Chart -- Admission Rates of Common Respiratory Disease and Injury	10
Chart -- Venereal Disease Admission Rates by Month	10
Chart -- Venereal Disease White Rates	11
Chart -- Venereal Disease Negro Rates	11
Chart -- Venereal Disease Total Rates	11
Table -- Venereal Disease Rates for US	12
Table -- Consolidated Venereal Disease Statistical Report	12
PROFESSIONAL SERVICES	
Protection from Allergy	3
Artificial Kidney Apparatus	4
Abstracts of Medical News Items	4
VETERINARY SERVICE	
Milk Sickness	5
Rabies Transmission	6
Table -- Veterinary Service	13



MAJOR GENERAL HERREN
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Washington 25, D. C.

ADMINISTRATIVE SERVICE

COMMAND RESPONSIBILITY

Colonel Robert E. Bitner, MC
Surgeon, Military District of Washington

"Not on medicine alone does the health of the command depend, but on those who have command." - Sir John Pringle.

How true are these words. The best medical staff giving the best medical advice in matters pertaining to the health of the command is helpless unless the officers who command are thoroughly indoctrinated in preventive health measures. This indoctrination must start on the first day an individual is commissioned, yes even before that day. In our military academies, in our ROTC, in our OCS, in every group training leading to officer status. Without the thorough indoctrination, without the real enthusiastic drive of the commanders of all ranks how can we expect the individual soldier to be enthused. Why should he worry about dysentery, malaria, frozen feet, typhus and the myriad of other diseases that will take him from the combat zone. Yes, the health of the command depends on the commanders.

Efficiency reports should reflect the interest of the troop commanders in regard to the health of his troops just as surely as it should reflect his economy of materials. There must be a reasonable balance at all times between materials present and man power to use those materials for carrying out missions.

Yes - the "health of the command depends on those who have command," and let us add, the accomplishment of a mission depends on the health of the command.

* * * * *

ARMY NURSE CORPS ENLIST SUPPORT OF NURSING SCHOOLS IN NEW DRIVE

Within the next several months, the Army Nurse Corps seeks to commission some recent graduate of every approved school of nursing in the United States. The American Nurses Association and state and regional nursing groups are giving full support to the campaign. The recruiting drive will open on the 51st anniversary of the founding of the Army Nurse Corps, and is being coordinated with the current Defense Department, "Share Service for Freedom," campaign to attract 72,000 more women into the armed forces by July 1. The present pattern for call to duty and return to civilian life of Nurse Corps officers differs from that seen in earlier emergencies. There has developed in our country's defense thinking, a philosophy calling for a continuous flow into, and exit out of our Armed Forces, of a larger segment of the national manpower. This new pattern offers large numbers of nurses an opportunity to serve for a shorter time.

If this philosophy of equal acceptance of the right to serve is to operate for the greatest good, appreciable numbers of young women must annually come into the Army Medical Service. Our national responsibilities, under this democratic policy must be accepted by the many unless they are to be assumed by the few.

In a letter to the directors of all accredited nursing schools, Colonel Ruby F. Bryant, Army Nurse Corps chief, said "We are proposing that a larger number of your nurses agree to serve for a short period in order to permit the early release of those who have already made their contribution to our defense effort.... We hope that you will join us in this program not only as a patriotic contribution but also to make it possible to promote a democratic equalization of the basic responsibilities that face the nursing profession today."

It is the desire of the Surgeon, MDW, that members of the ANC in this command publicize this drive among civilian nurses of their acquaintance and do all in their power to make this campaign a success.

ADMINISTRATIVE SERVICE

THE ROLE OF THE MEDICAL DEPARTMENT IN PAST WARS

Revolutionary War -- War of 1812

On a secret expedition--one of the most heroic ventures of the American Revolution--about five hundred ragged, rugged colonists, with four rounds of ammunition each, attacked the city of Quebec and maintained a hopeless, six-month siege without shelter or equipment and with many of the men seriously wounded. The Physician and Surgeon of the Troops, detached from the American Army at Cambridge, Massachusetts, to serve on the expedition, lost all his instruments, "but saved a pocket lancet and was still able to let blood."

The Physician and Surgeon of the Troops was one of twelve hundred physicians who joined other colonists in the fight for freedom, fought in the line with them, and applied to the best of their ability the medical knowledge of the day. These physicians were the first military medical men of a united America, and their task was to provide medical service for a hastily organized army of citizens. Their problems were multiple; they lacked organization, battlefield experience, hospitals, and supplies.

During the course of the revolution General George Washington, Commander in Chief of the Army, requested an organized medical service for his army of twenty thousand men, maintaining that "the lives and health of both officers and men so much depend on a due regulation of this department." On 27 July 1775 the Continental Congress passed a bill providing for a Hospital, or Hospital Department, with personnel to include a chief surgeon, four surgeons, one apothecary, and 23 subordinate personnel.

Lacking in precedents and centralized control of medical facilities and limited by a demand for strict economy, the Hospital Department progressed slowly. It was called upon to serve in the War of 1812 with a medical provision of one additional surgeon and two assistants for each of the thirteen additional regiments. In this war, as in the Revolutionary War, surgical practice was at a minimum. Anesthetics were not in use and blood-letting was still considered a cure-all. Then, "the more blood expended the better the wounds of the viscera, provided life was not extinguished when the hemorrhage was stopped." In both wars medical service for the sick was a greater problem than the care of the wounded; there were more deaths from diseases and wound infection than from enemy action. Experience gained in these and subsequent wars, however, furnished the basis from which was to evolve the present highly organized and coordinated scheme of military medical service.

(This is the first of a series of articles on the History of Military Medicine and the Traditions of the Medical Department of the United States Army.)

(The above article is from Training ORC Bulletin, Med. Dept. US Army, Brooke Army Medical Center, Fort Sam Houston, Texas)

* * * * *

DISINFECTING GAS MASKS

The following basic procedure for effecting adequate cleaning of the mask is suitable for both small or large scale operations:

After prolonged use or when the gas mask is to be turned in for reissue, all rubber parts should be cleaned by thorough washing with lukewarm soap and water solution which should be followed by adequate rinsing with clean water and subsequent drying at room temperature. Under no conditions should the rubber components of a gas mask be sterilized by boiling or autoclaving and care must be exercised to prevent water from getting into the canister.

(The above is from an MDW Letter, File ANWCM 475, dated 17 March 1951)

PROFESSIONAL SERVICES

PROTECTION FROM ALLERGY

By taking precautions to avoid exposure to substances known to be highly allergenic to the skin, to the respiratory or digestive tracts, or to other organs, allergic persons, and those who have such tendencies, can be spared much discomfort and illness. Each patient will learn from his physician what preventive measures are desirable in his own case, but the following general suggestions may be helpful.

The earlier an allergic disorder is discovered and treated, the better the outcome is likely to be. Early treatment may help to prevent the development of complications or of a second disorder.

Every effort should be made to build up resistance to respiratory infections by healthful living habits.

Points of infection should be treated or removed, if possible, before an allergy develops.

It is wise for allergic persons to try to avoid emotional tension and nervous fatigue, since the emotions influence the severity and frequency of attacks. Emotional instability in itself may be a factor in allergic-like manifestations.

Allergic persons should be tested before having an injection of a drug, vaccine, or serum; for example, before being given liver extract, or being immunized against a communicable disease. Care should be taken in the use of any drug which might cause sensitivity.

It might be well for allergic persons to reduce their contact with the substances which are common causes of allergy.

Do not walk through fields of ragweed.

Do not travel through the country in an open automobile during the pollen season.

Avoid drafts and long exposure to cold, raw air; for example, do not sleep out of doors or directly in front of open windows during cold weather.

Take sensible measures to reduce exposure to house dust and other types of dust; for example, stay away from attics and other dusty places.

Avoid inhaling strong fumes, powders, disinfectants and insecticides, or other products which contain pyrethrum or other ingredients that might be irritating to the respiratory tract.

Avoid using on your skin, hair, and nails, or allowing your skin and hair to come into contact with, an unnecessary number of drugs, medications, cosmetics, dyes, plants, insecticides, strong cleansers and the like.

Special precautions should be taken to protect infants and children with known allergic tendencies.

Follow the physician's advice about the diet of infants and young children. Boiled fluid milk, dried milk, and evaporated milk are less likely to cause allergic reactions than plain fluid milk. Whole eggs, raw vegetables, and fruits should be introduced into the diet slowly. Overfeeding should be avoided.

Have infants and young children immunized against diphtheria, smallpox, whooping cough, and tetanus.

Keep the nursery or the nursery space as dust-free as possible.

Do not have cats, dogs, or birds in the house.

Do not allow the child to sleep with stuffed woolly toys which might contain rabbit hair, horse hair, or other common allergens.

Be alert to mannerisms which might indicate allergic symptoms--sniffing or wrinkling the nose, or rubbing the eyes or nose.

(The above article from booklet "Allergic to What?" published by the Metropolitan Life Insurance Co.)

PROFESSIONAL SERVICES

ARTIFICIAL KIDNEY APPARATUS

An artificial kidney apparatus is now available at both Brooke Army Hospital and at Walter Reed Army Hospital for treatment of patients at these two facilities. Direct communication between hospital commanders is authorized in regard to transfer of patients whose condition would be benefited by the utilization of this equipment.

Prior to the movement of a patient, as much advance notice should be furnished the receiving hospital as is practicable. Transfer of such patients will be accomplished in accordance with SR 40-530-5.

(The above is from SGO Circular No. 15, Section II, dated 22 January 1952).

* * * * *

ABSTRACTS OF MEDICAL NEWS ITEMS

FROM "THERAPEUTIC NOTES" VOL. 59, NO.1

COMPRESSES OF BENADRYL

Compresses of Benadryl 2 per cent solution in sterile water, employed in therapy of 60 cases of burns and scalds resulted in earlier relief of pain, rapid diminution in intensity of erythema and less frequent appearance of blistering, the best results being observed in patients treated within the first four hours. An impressive lack of secondary infection was noted. W. K. Slack, et al., Brit. M. J. 2:360, 1951.

CHLOROMYCETIN

Chloromycetin was effective in treatment of puerperal and nonpuerperal pelvic inflammatory disease. There was rapid disappearance of peritonitis and regression of tubo-ovarian inflammatory masses. Patients were ready for exploratory laparotomy, where indicated, in three to four weeks. C. S. Stevenson, Am. J. Obst. & Gynec. 61:498, 1951.

FRIEDLANDERS' PNEUMONIA

Friedlanders' Pneumonia responded to Chloromycetin in a patient treated by the authors who state: "On the basis of clinical response and sensitivity studies with this patient's organisms, we are encouraged to believe that Chloromycetin may be a superior therapeutic drug for Friedlanders' pneumonia." H. Z. Pomerantz et al., Boston M. Quart. 2:23, 1951.

OPTIMAL DOSAGES

Optimal Dosages have not been determined for Chloromycetin in all infections. In many, but possibly not all, patients with pneumococcal and other bacterial pneumonias, 1 Gm. daily is adequate. In pneumonias caused by gram-negative bacilli, and especially Friedlanders' bacillus, 3 or 4 Gm. daily is indicated until further information is available. W. M. M. Kirby, et al., J. A. M. A. 147:110, 1951.

PENICILLIN OINTMENT

Penicillin Ointment is the most efficacious, safest and least irritating agent for prophylaxis of gonorrheal ophthalmia in hospital practice, and where necessary, statutes and health regulations should be changed to permit its use. H. H. Davidson, et al., J. A. M. A. 145:1052, 1951.

VETERINARY SERVICE

MILK SICKNESS

by

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Military District of Washington

Milk sickness in man and trembles in animals results from poisoning with the white snake-root or the rayless goldenrod. This disease is due to trematol ($C_{16}H_{22}O_3$) an optically active alcohol which is one of the toxic constituents of white snakeroot (*Eupatorium urticaefolium*) and rayless goldenrod (*Aplopappus heterophyllus*). Trematol is the responsible agent in white snakeroot; the toxic agent in the rayless goldenrod is somewhat different in nature. Milk sickness is due to a chemical poison. This is in distinction to other animal diseases which are bacterial in nature.

White snakeroot grows in densely wooded areas from Minnesota to Louisiana and east to North Carolina. It has been known to grow in pastures, however, and is found sparingly over a wide area in urban and rural communities. The rayless goldenrod is distributed over a wide territory from southern Colorado to the Texas Panhandle and south to Arizona, Sonora and Chihuahua. It is especially abundant in the irrigated portions of the Pecos Valley in Texas and New Mexico.

The history of milk sickness dates back to 1776 in North Carolina. It was a serious affliction among the early settlers of the Middle West taking many human and animal lives. Herndon, writing about Abraham Lincoln, describes the ravages of milk sickness in Kentucky, telling how whole settlements were abandoned to get rid of the peculiar malady. "In the fall of 1818, the scantily settled region in the vicinity of Pigeon Creek - where the Lincolns were then living - suffered a visitation of that dread disease common in the West in early days, and known in the vernacular of the frontier as the milksick! It hovered like a spectre over the Pigeon Creek settlement for over ten years and its fatal visitations and inroads among the Lincolns, Hanks, and Sparrows finally drove that contingent into Illinois. . . . It not only took off the people but it made sad havoc among the cattle. One man testifies that he lost four milk cows and eleven calves in one week. . . This, in addition to the risk of losing his own life, was enough, he declared, to ruin him, and prompted him to leave for points farther west! . . . Early in October of the year 1818, Thomas and Betsy Sparrow fell ill of the disease and died within a few days of each other. Thomas Lincoln performed the services of undertaker Meanwhile Abe's mother had fallen a victim of the insidious disease. Her sufferings, however, were destined to be of brief duration. Within a week she, too, rested from her labors."

Trembles appears in pastured animals, horses, cattle and sheep being the ones most naturally affected. These two plants are frequently eaten by animals in autumn as a last resort when all other vegetation is dry. The course of the disease is practically the same whether due to white snakeroot or rayless goldenrod.

Milk cows exposed to white snakeroot may transmit the poison through the milk without showing any symptoms of the disease. It appears that the milk absorbs the toxin, thus protecting the cow while she is lactating, however, when the animal goes dry the system at once becomes susceptible and the disease runs its usual course showing the following symptoms: depression, dull appearance, abnormal thirst, loss of weight, constipation and the characteristic trembling of voluntary muscles. Finally the animal becomes completely debilitated and is unable to rise. The breath has a marked pungent odor. The pulse and respiration become irregular and slow as coma appears, followed by death.

No animal probably is immune from trembles, for in addition to horses, cattle and sheep, it has been observed in mules, swine, chickens, rabbits, dogs, cats and guinea pigs. Prevention of the disease is better than attempts to cure it because cure is not always certain.

Milk sickness in man results from ingestion of trematol in milk, cheese and butter from cattle which have eaten white snakeroot or rayless goldenrod. The poison is cumulative, causing weakness, restlessness and exhaustion in the early stages. This is followed by abdominal pain, vomiting, constipation, abnormal thirst, loss of appetite, weak pulse, labored breathing, and subnormal temperatures. The throat and intestinal tract apparently become paralyzed and in fatal cases is often preceded by a prolonged coma. Relapses are common and the mortality is high in such instances.

VETERINARY SERVICE

Mortality resulting from this disease is about twenty-five percent. Prevalence of the disease in man is difficult to estimate as very few of the actual cases are reported. Education of the public has had a marked effect upon human affections.

Trematol may be altered by heat or by chemical reagents and when so changed it loses its poisonous properties, however, the temperature required for the pasteurization of milk does not affect it. Trematol is rapidly destroyed by drying so that completely dried snakeroot is incapable of producing trembles, but the poison of the rayless goldenrod is not destroyed by drying and this plant is dangerous to animals either green or dry.

The prevention of trembles in animals, and indirectly that of milk sickness in man, depends upon avoiding pastures badly infested with these two plants. This can be accomplished by the systematic pulling, drying and burying of these plants in September and again in October. Prevention of milk sickness in humans depends upon avoiding milk products from affected cattle. As mentioned previously, pasteurization does not render milk which contains this poison safe for human consumption. However, under normal market conditions such poisoned milk is diluted sufficiently with milk from other sources to render it harmless. There need be little fear of outbreaks of great magnitude among city dwellers. Milk sickness is a rural problem and therefore, education and prevention must rest with the farmer.

References

1. Dack, G.M., Food Poisoning, Chicago, 1943.
2. Hull, Thomas G., Diseases Transmitted from Animals to Man, Springfield, 1947.

* * * * *

RABIES TRANSMISSION

Rabies is not transmissible by fleas or any other arthropods.

Domestic fowl may contact rabies, although they are not so susceptible as mammals. No instance is known in which rabies was transmitted by rabid chickens.

Natural transplacental transmission following natural infection in dogs has been recorded. However, Konradi (Zentralbl. Bakt. 42 (pt. 1):203, 1908) observed that rabies could be transmitted by pregnant dogs, following experimental infection, to the fetus and offspring. Others fail to confirm this transplacental passage of the virus.

Transmission of rabies to a surgeon or pathologist whose knife slipped is not unlikely. Accidental contamination of the wound would be more likely from contact with pancreas, kidney, or mammary glands than from the knife since the virus may sometimes be present in these tissues.

Rabies virus has been recovered from the urine or milk of rabid animals. Infection from the handling of infected milk or urine is a very improbable mode of transmission. The danger of such occurrence would depend on the entry of the infected fluid into a substantially severe and fresh wound and also on the concentration of the virus in the contaminating fluid. Ingestion of infected cow's milk is a highly unlikely mode of transmission.

If a dog is immunized and fully protected, remaining refractory to infection, he will not be capable of transmitting the virus. In dogs there is no evidence of symptomless carriers of rabies whether immunized or not.

Extracted from Journal of the American Medical Ass'n (July 21, 1951, p. 1175)

GENERAL COMMENT

The health of the command continues to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 8).

The non-effective rate* decreased from the December rate of 15.78 to 15.65 for the month of January. Days lost as a result of disease and injury totaled 16,653 during the five week period ending 30 January 1952.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$

Non-Effective Rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in January was 469.2, compared to 330.4 during December. Total admissions for disease and injury in January was 1368. Of this number 1270 admissions were for disease and 98 injuries. Fort Myer reported the highest admission rate, and the US Army Dispensary, The Pentagon reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

January's rate for disease cases is 435.6 for 1270 cases. Fort Myer reported the highest admission rate, and Fort McNair reported the lowest rate for disease cases.

An injury admission rate of 33.6 per 1,000 per annum for January was reported. This was a decrease from the December rate of 40.2. Fort Myer reported the highest rate and the US Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were no deaths reported during the five week period ending 30 January 1952, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of January 1952. The rate for the present month is 201.3 compared to the December rate of 115.6. Fort Myer reported the highest rate, and All Others reported the lowest rate. Admission rates for pneumonia (all types) decreased during the January report period. The rate being 6.1 compared with the December rate of 6.9. There were no cases of scarlet fever reported throughout the month of January.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the five week period ending 30 January 1952.

Pertinent statistical tables may be found on pages 8 and 13.

PREVENTIVE MEDICINE

GENERAL DATA
5-Week Period Ending 30 January 1952
(Data from DD Forms 442)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes Cases	All Causes Rates	Disease Cases	Disease Rates	Injuries Cases	Injuries Rates		
Fort Belvoir, Virginia	18320	16210	2110	822	467.89	781	444.56	41	23.34	16.70	0
Fort McNair, Wash, DC	919	847	72	39	442.54	33	74.45	6	68.08	9.05	0
Fort Myer, Virginia	3992	3829	163	267	697.46	226	590.36	41	107.10	11.04	0
US Army Dispensary The Pentagon	4004	3979	25	117	304.71	112	291.69	5	13.02	21.44	0
All Others	3167	3160	7	123	405.00	118	388.54	5	16.46	10.00	0
Total - Military Dist. of Washington	30402	28025	2377	1368	469.23	1270	435.61	98	33.62	15.65	0
AMC-Medical Detachment (Duty Personnel)	1691	1555	136	102	629.00	98	604.40	4	24.60	24.20	1

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
5-Week Period Ending 30 January 1952
(Data from DD Form 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Virginia	208.33	7.97	7.40	65.46	23.91	-	-	-	-	.57	-	3.42
Fort McNair, Wash, DC	136.17	11.35	-	-	-	-	-	-	-	-	-	-
Fort Myer, Virginia	342.20	2.61	2.61	-	-	-	-	-	2.61	-	-	5.22
US Army Dispensary The Pentagon	145.85	2.60	2.60	2.60	2.60	-	-	-	-	-	-	2.60
All Others	72.44	3.29	-	-	3.29	-	-	-	-	3.29	-	-
Total-Military District of Washington	201.34	6.17	5.15	39.79	15.09	-	-	-	.34	.69	-	3.09
AMC-Medical Detachment (Duty Personnel)	172.60	-	-	-	6.10	-	-	-	-	-	24.60	-

PREVENTIVE MEDICINE

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VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the January report period.

The rate for January 1952 was 11.66 a decrease from the December rate of 12.56. A total of 34 cases were reported for the five week period ending 30 January 1952. Fort Belvoir reported all of the total number of Venereal Disease cases.

During the report period, white personnel incurred 5 of the reported number of cases, with a rate of 1.86 and 29 were incurred by Negro personnel with a resulting rate of 127.22 per 1000 Troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (January) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 10 and 12.

NEW VENEREAL DISEASE CASES - EXCEPTS - NOVEMBER 1951, DECEMBER 1951, AND JANUARY 1952

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	NOVEMBER '51	DECEMBER '51	JANUARY '52	JANUARY '52
Fort Belvoir	16.72	18.46	19.35	1.855
Fort McNair	14.80	28.46	-	-
Fort Myer	3.35	-	-	-
US Army Dispensary, Pentagon	-	-	-	-
All Others	-	4.46	-	-
Total - Military District of Washington	11.09	12.56	11.66	1.118
Army Medical Center - Medical and Holding Detachments	28.21	20.22	32.88	3.152
Total - Dept/Army Units Mil Dist/Wash	12.79	13.30	13.67	1.310

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

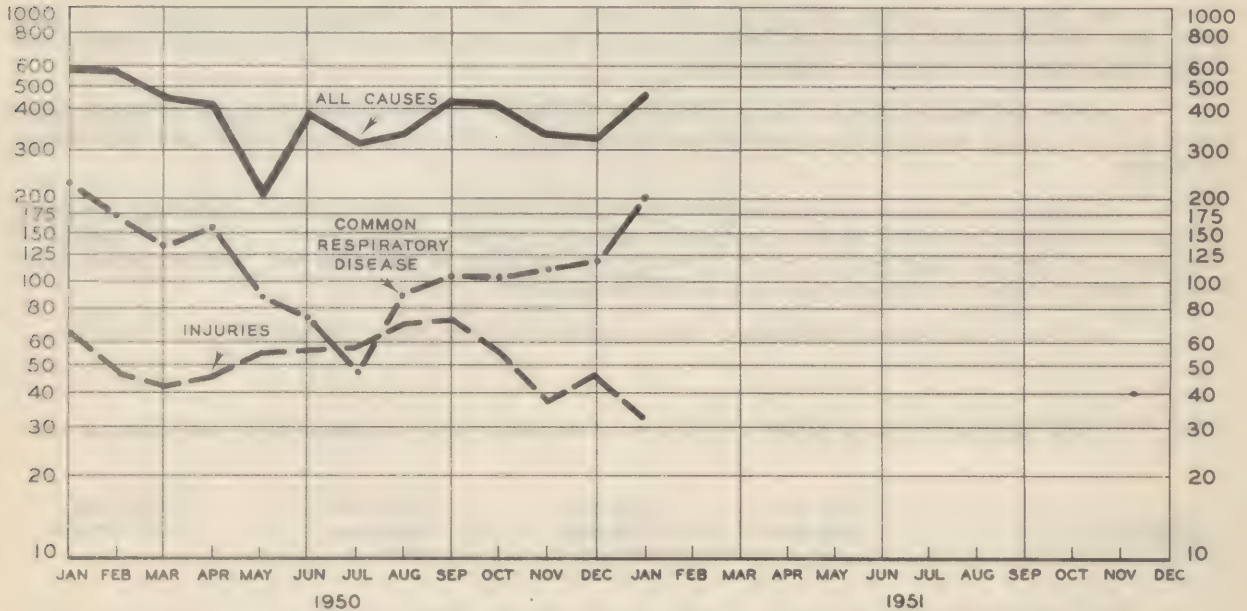
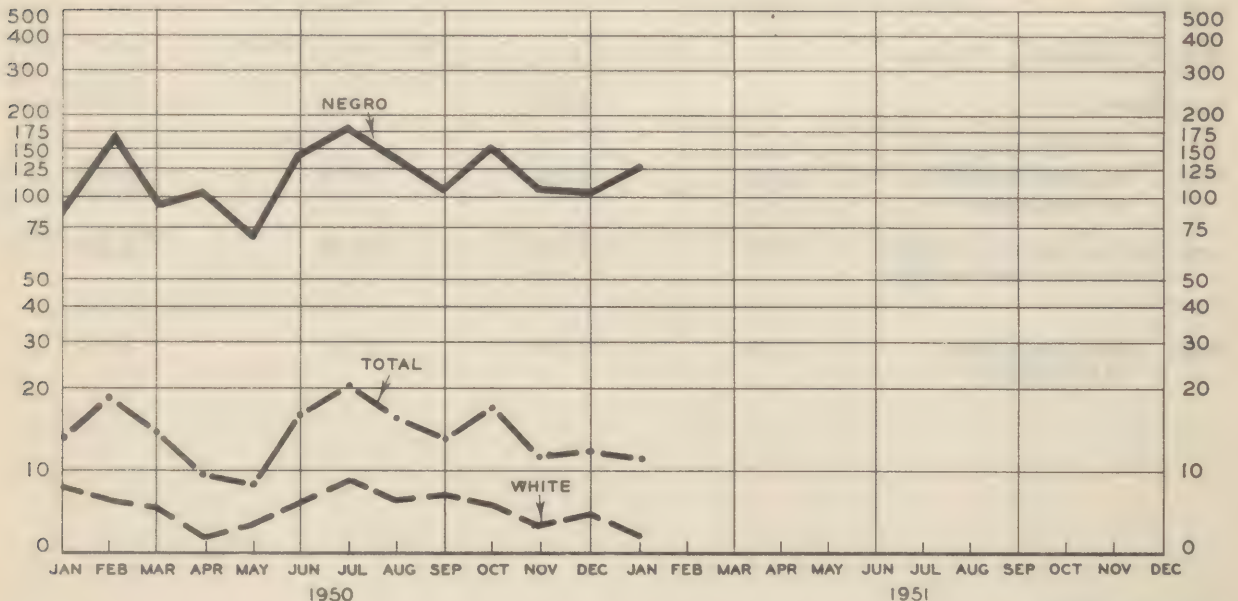


CHART 2

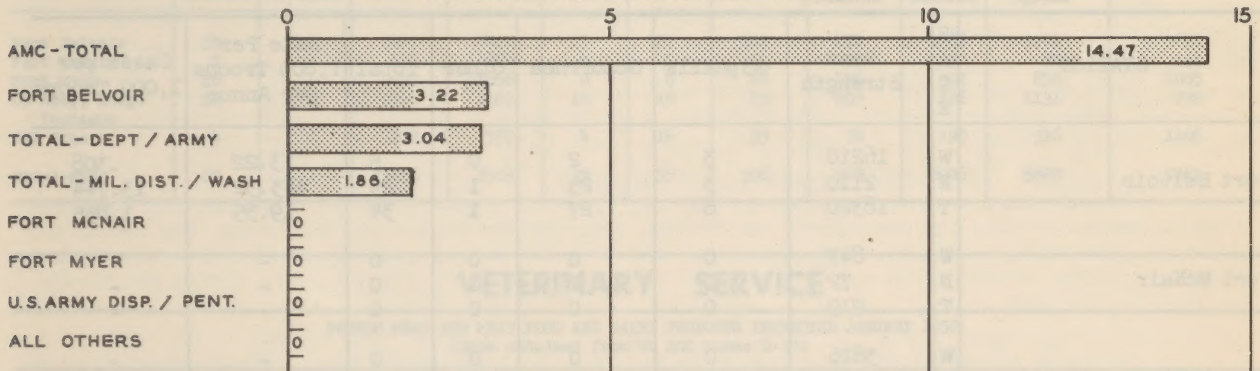
ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



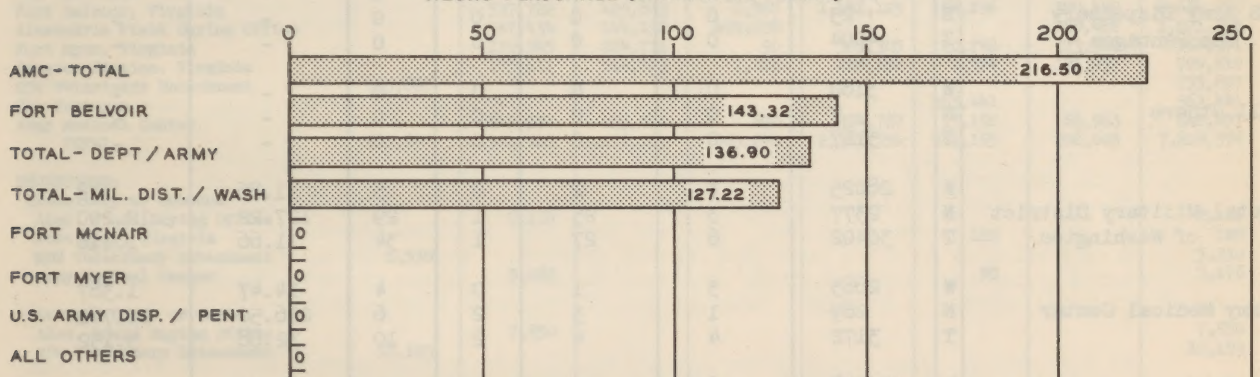
PREVENTIVE MEDICINE

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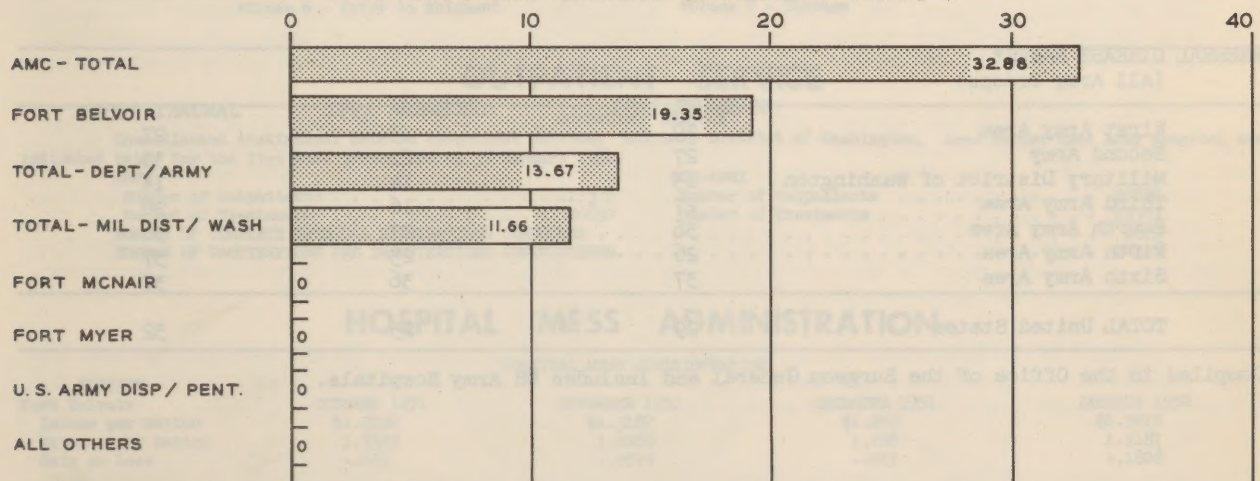
VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 30 JAN 1952 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 30 JAN 1952 NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 30 JAN 1952 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



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PREVENTIVE MEDICINE

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT
For the Five Week Period Ending 30 January 1952
(Data from DD Forms 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rate Per 1,000 Troops per Annum	Cases per 1,000 Troops
Fort Belvoir	W	16210	3	2	0	5	3.22	.308
	N	2110	3	25	1	29	143.32	13.744
	T	18320	6	27	1	34	19.35	1.855
Fort McNair	W	847	0	0	0	0	-	-
	N	72	0	0	0	0	-	-
	T	919	0	0	0	0	-	-
Fort Myer	W	3816	0	0	0	0	-	-
	N	163	0	0	0	0	-	-
	T	3992	0	0	0	0	-	-
US Army Dispensary The Pentagon	W	3979	0	0	0	0	-	-
	N	25	0	0	0	0	-	-
	T	4004	0	0	0	0	-	-
All Others	W	3160	0	0	0	0	-	-
	N	7	0	0	0	0	-	-
	T	3167	0	0	0	0	-	-
Total-Military District of Washington	W	28025	3	2	0	5	1.86	.178
	N	2377	3	25	1	29	127.22	12.200
	T	30402	6	27	1	34	11.66	1.118
Army Medical Center	W	2883	3	1	0	4	14.47	1.387
	N	289	1	3	2	6	216.50	20.761
	T	3172	4	4	2	10	32.88	3.152
Total-Dept/Army Units	W	30908	6	3	0	9	3.04	.291
	N	2666	4	28	3	35	136.90	13.128
	T	33574	10	31	3	44	13.67	1.310

VENEREAL DISEASE RATES*
(All Army Troops)

	NOVEMBER 1951	DECEMBER 1951	JANUARY 1952
First Army Area	29	23	27
Second Army	27	21	33
Military District of Washington	13	14	14
Third Army Area	27	16	28
Fourth Army Area	36	27	36
Fifth Army Area	26	25	37
Sixth Army Area	37	36	37
TOTAL United States	29	23	32

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals.

DENTAL SERVICE

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DENTAL SERVICE - FIVE WEEK PERIOD ENDING 30 JANUARY 1952

STATION	Total Dentists		Sittings	Fillings	Bridges	Crowns	Dentures	Calculus Removed	Teeth Removed	Roentgenograms	Examinations
	Officer	Civilian									
Fort Belvoir	32	0	8827	4427	17	21	203	455	1486	3241	5637
Fort McNair	2	0	434	284	4	0	21	10	30	82	131
Fort Myer	10	1	2659	1066	0	0	28	156	322	850	1055
US Army, Disp. Pentagon	12	0	2924	2169	10	18	29	209	196	1131	932
All Others	4	0	1212	557	4	16	25	78	192	316	1406
Total-MDW	60	1	16056	8503	35	55	306	908	2226	5620	9161

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED JANUARY 1952
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		71,636	114,227		177,183		62,616	425,662
Fort Belvoir, Virginia		537,722	429,843	1,567	1,151,123	174,196	390,499	2,684,950
Alexandria Field Buying Office		347,434	144,192	499,698			80,462	1,071,786
Fort Myer, Virginia		179,945	224,711	90	365,305	20,792	173,528	964,371
Cameron Station, Virginia		175,611	114,523	1,015	289,152	7,574	121,937	709,812
MDW Veterinary Detachment	755,897							755,897
The Pentagon						363,441		363,441
Army Medical Center		249,574	125,071	870	384,787	15,192	66,963	842,457
TOTAL	755,897	1,561,922	1,152,567	503,240	2,367,550	581,195	896,005	7,818,376
REJECTIONS:								
Insanitary or Unsound								
Alex. Field Buying Office		2,116						2,116
Fort Myer, Virginia						122		122
MDW Veterinary Detachment	5,530							5,530
Army Medical Center		5,083				95		5,178
Not Type Class or Grade								
Alex. Field Buying Office		7,850						7,850
MDW Veterinary Detachment	10,193							10,193
TOTAL	15,723	15,049				217		30,989

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Army Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - At Issue

*Class 8 - Purchase by Post Exchange, Clubs
Messes or Post Restaurants

*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital are indicated below for the five week period ending 30 January 1952:

ARMY:

Number of Outpatients 17375

Number of Treatments 20630

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1859

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 24316

NON-ARMY

Number of Outpatients 20835

Number of Treatments 23303

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1859

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 24316

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	OCTOBER 1951	NOVEMBER 1951	DECEMBER 1951	JANUARY 1952
Fort Belvoir				
Income per Ration	\$1.3222	\$1.3187	\$1.269	\$1.3015
Expense per Ration	1.3335	1.2668	1.286	1.1187
Gain or Loss	-.103	+.0519	-.017	+.1828

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CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

THE INDUSTRIAL HEALTH TEAM

"He travels fastest who travels alone." That aphorism, like most others, expresses only a half truth. Clearly the industrial physician travels only slowly toward achievement when he elects aloofness from those other individuals and industrial services likewise dedicated to conservation of the worker's total physical and mental well-being. Every person in industrial employment influences to some degree the well-being of one or more workers about him. More importantly, in addition to the industrial physician, inevitably there are other persons serving the workers on a professional basis who unfailingly influence the health of the entire plant force.

Potentially, a health team always exists, but the actuality of the team and the team work is by no means certain. The members of the desired team are the physician, the nurse, the industrial hygienist, the safety engineer, the employment manager; in varying degree all function to a common objective--worker conservation and development. The ingredients for a team nearly always are around, but rare is the team.

No issue is raised that the physician should command the team, but the leadership of it is a different matter. The physician's leadership should be both professional and personal. A company of lions commanded by a goat becomes a company of goats. A company of goats commanded by a lion becomes a company of lions. Or, for a pure translation of the old Roman proverb: "An army of stags led by a lion would be better than an army of lions led by a stag." Since the apex of the team's work unequivocally is medical, the industrial physician, to be effective, cannot escape the responsibilities of team leadership.

The physician continually may give lip service to this matter of continuing betterment in human relations, but day by day create havoc by lack of proper human relations right in his own office. One capable, but bitter, industrial nurse complained, "I have been here eight years. My medical director on the same floor doesn't even know my name, and wouldn't recognize me out of uniform." This same director might not know the name of the safety director except on referral to the plant phone books, and to this same physician, the fact that the employment manager's wife wrecked the family care, sadistically is but a good joke on that manager. The industrial physician's human relations program is never better than those relations he creates in his own department and within the professional team.

At this period, when the need for team action is more than ever apparent, the disposition among the team segments is toward resentful apartness. The industrial hygienist, in prideful professional growth, is building scornful class walls. The nurse, industrial and otherwise, frets endlessly that she is in a captive profession and seeks release and new professional worlds attended by fewer restraints. The safety engineer knows full well that a limit approaches in his usefulness only in terms of guards, goggles, and inspections. The employment manager--but why iterate? Philosophy has been defined as profound research into the obvious. The desirability of team work in industrial health requires not profound philosophy or any change in philosophy. The situation is irrefutable.

In a past not far removed, all the mentioned team members functioned in divergent worlds. This state represented fallibility. The physician then chiefly was concerned in the worker's wounds and not the worker. The safety engineer in that period focused his ministrations upon machines and not upon the workers who operate them. Some nurses applied themselves to precise records rather than the individual whose name appeared at the top of the sheet. The industrial hygienist--but again the iteration. Now as a product of the slow gropings of progress, one and all have made an illuminating discovery. Overwhelmingly the objective of industrial health is the worker himself--the whole man. Upon him all personnel services ultimately converge.

There is no tenability in the concept of an exploding universe in the services devised for the conservation of the industrial worker. Convergence is the word--the pooling of objectives and plans--the integration of ministrations--the team.

(The above article is from "Industrial Medicine and Surgery", February 1952, Volume 21, Number 2).